North Dakota State Trauma Coordinators

March 2007

Newsletter

How Trauma Designation Changed a Small Rural Hospital

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Nearly two years ago, I became the new "Outpatient coordinator" at Lisbon Area Health Services. This position was created to designate someone responsible for coordinating the emergency room and outpatient services under direction of the Director of Patient Care (DPC). When I applied for this position, I truly never knew just how frustrating, yet rewarding, it would be.

Once "settled in" to my new position, our DPC, Peggy Larson, brought up the topic of trauma designation. This was a goal that she had for our facility for the past couple of years, but with so many projects already underway, there had been no one who was able to give it the time and attention that was required to complete this task. So, with Peggy as my cheerleader, I set out to discover the process involved with obtaining a Level IV trauma designation for our facility.

The first task at hand was muddling through the application itself. There were seemingly pages, upon pages, of questions that we needed to answer: How many ED visits in the last year? Number of ED visits due to injury last year? Number of patients meeting the definition of a major trauma patient in the last year? The questions seemed easy, but in our small rural facility, we didn't have all of these numbers right at our fingertips. We had to find them.

By now, anyone that is involved in an established trauma center knows exactly what level we were at when we started this process. We literally started from the ground and worked our way up! Today, we have a tracking system and every trauma case is reviewed for Performance Improvement and Patient Safety indicators on four different levels. However, this change did not come without many growing pains. All of the staff at LAHS went through a "brain transplant" so to speak. While we had been delivering good patient care to anyone that came through our doors, we were not yet "trauma minded". Many staff members asked "why do we need this anyway?? We have always given proper care, no one has died because of the way we do things here"!

Seeking a Level IV trauma designation meant that we sent 100% of our ER nurses through TNCC. Several of us had been through this course four years prior, "but we never really practiced what we learned". This time, it was different. Each one of us came back determined to not fall back into old ways, and vowed to keep that "trauma team approach" when caring for all of our trauma patients. Of course, that was another good topic, "What IS a trauma patient"? When do we CALL a trauma code"? "Do we HAVE to call the trauma code over the intercom? Everyone that would respond is already here"! These are all questions that we don't ask anymore. It is all very clear.

What I haven't told you is that we have become a designated Level IV trauma center in the last year…TWICE! That is right, twice. We applied and became designated for a 6-month period while we "grew our system". Six months later, we were re-surveyed and lost our designation. I will admit, all of the air left my chest that day! Something that we had been working so hard for, and had become so proud to advertise to the public, was no longer true. What happened? Did we treat a patient inappropriately? Did we report something incorrectly? No, none of that contributed to the loss of our designation. In fact, it was nothing that we had done, but those things that we had not done. Our documentation was not clear, our QA did not have "loop closure", and we still did not used Morphine or Fentanyl as our main pain medication for our injured patients. "Loop closure"? I still wasn't real sure what that meant. Documentation? We had a new flow sheet, which provided much more information than we used to get on our patients, but it was not enough.

At this point, and as a small hospital in rural ND, we were well aware that this was not a good thing for our community. According to ND Century Code, not being a trauma center meant, that if a patient was critically

injured, EMS would have to bypass our facility for a trauma designated facility, over 90 minutes down the road from us. This could mean that our patients, many who are our own friends and relatives, had a risk of dying because we were deemed inappropriate for trauma care. It meant the difference between life and death for the people in our community.

So, just 24 hrs. after the official un-designation visit, and after a couple of people asked "why do we need this anyway? We took care of these same patients before we were ever designated, why can't we take care of them now?", we took a deep breath in, and were ready to get back to work at regaining our Level IV designation.

The State Trauma survey team suggested we wait 6 months before we re-applied for the Level IV designation. We knew we wanted it back way before then, we also knew that it wouldn't be easy! We had to ask ourselves, "Where do we start"? I knew that I had to first figure out what "Loop Closer" really was! Currently, we have developed our PIPS system that we are not only proud of, but is spilling out over into other departments within our facility, and will help us to continue the evolutional process that we need to keep from becoming complacent in what we do. Our trauma documentation was developed by the best, and will stand up to the best. Our nurses took ownership in this piece of paper, and we have perfected it. We can now paint a picture of every patient's stay so beautifully, that if it weren't for HIPPA, would belong on a wall in every museum!

These things, and the processes that got us here really made

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2006 ND Trauma Designations

IV	Ashley Medical Center, Ashley
IV	Carrington Health Center, Carrington
V	Community Memorial Hospital, Turtle Lake
IV	Lisbon Area Health Services, Lisbon
V	McKenzie County Health Care Systems Hospital, Watford City
V	Mercy Hospital, Devils Lake
IV	Mercy Medical, Williston
II	Meritcare Hospital, Fargo
V	Mountrail County Medical Center, Stanley
IV	Oakes Community Hospital, Oakes
IV	Quentin Burdick Health care Facility, Belcourt
II	St. Alexius Medical Center, Bismarck
IV	St. Aloisius Medical Center, Harvey
IV	SW Health Care Services, Bowman
IV	Towner County Medical Center, Cando
V	Union Hospital, Mayville
IV	Unity Medical Center, Grafton
V	Wishek Community Hospital, Wishek

How North Dakota Kids Ride

The North Dakota Department of Health has completed its biennial observation surveys to measure restraint use by children under age 11. The surveys were conducted between May and September 2006 by certified child passenger safety instructors and were done in Bismarck, Jamestown, Valley City, Fargo, Wahpeton, Grand Forks, Devils Lake, Minot, Williston and Dickinson.

In the ten communities, observers recorded data on 1,937 children with 191 determined to be under age one; 775 were categorized as toddlers age one through five; and 971 were determined to be children ages six through ten. Survey results showed:

- 98.4 percent of infants less than one year of age were riding in a car safety seat.
- 90.5 percent of toddlers ages one through five were buckled in a car seat, booster seat or seat belt.
- 82.2 percent of children ages six through ten were restrained in a seat belt, booster seat or car seat.

Restraint use increased in all age categories between the 2004 and 2006 surveys. In 2004, restraint use by infants was 97.4 percent and restraint use by toddlers was 85.4 percent. In 2004, 78.2 percent of children ages six through ten were restrained.

February is Child Passenger Safety Month! Child passenger safety activities conducted by local agencies should begin statewide soon! For more information call Dawn at 800.472.2286, press one.

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us the level IV trauma center that we are today. This is true because it forced us look deep inside ourselves and see who and what we really were as a health care facility. It allowed us to stretch as we reached higher that we had ever before, to become the facility that we want to be. Most of all, we did it as a team. From the Physicians, to the administrative staff, we ALL changed our way of thinking and acting when that radio alerts us to an injured patient. We know now, that the trauma code isn't over when that patient leaves the walls of our facility, but their impression here will last a lifetime. Each new patient gives us the opportunity to learn and grow. We are truly better doctors, nurses, advocates, and neighbors for having gone through this entire designation process, twice. We don't just give good patient care here at LAHS, now, we can honestly say, we give great care to ALL of our patients, trauma patients included! TEAM: Together Everyone Achieves More. We here at Lisbon Area Health Services certainly have, and we are so proud of it!

OUR OPINION : Say 'yes' to graduated driver's licenses

Tom Dennis for the *Herald*

Kudos to State Sen. Tim Mathern, D-Fargo, for introducing a bill to let teen drivers in North Dakota gain experience through a graduated driver's license system.

Mathern's bill would bump up the age at which a young person could get a driving permit from 14 to 14½. In addition, "teens would enter a provisional phase until they're 16½ after completing the permit phase," The Associated Press reported.

"During this time, they could not transport more than one passenger younger than 18 unless someone at least 21 is sitting next to them… Teens in this phase would also have to be accompanied by someone at least 21 years old if they're driving from 11 p.m. to 5 a.m.

"Teens could not talk on their cell phones while driving during the provisional phase."

The National Transportation Safety Board ranks as one of the most respected agencies in Washington. It' ;s nonpartisan, science-based, impartial and absolutely fearless; its investigations into airline crashes, for example, are models of truth-telling and straight talk. Those investigations and their "lessons learned" are one reason why American aviation ranks among the safest in the world.

The board investigates highway safety practices, too; and in the matter of graduated driver's licences, its conclusion is clear: The board is 100 percent for it.

The following is an excerpt from the National Transportation Safety Board's policy statement on graduated driver's licenses. The reform is on the board's list of "Most wanted" changes in highway safety because of its proven effect on reducing the teen death rate in car crashes.

"Motor vehicle crashes remain the leading cause of death for 15- through 20-year-olds," the board notes.

"From 1996 through 2005, almost 64,000 youth aged 1 5 through 20 died in traffic crashes - 122 each week.

"In 2004, 3,620 drivers 15 through 20 years old were killed, and an additional 300,000 15- through 20-year-olds were injured in motor vehicle crashes. In 2004, 7,898 15- through 20-year-old drivers were involved in fatal crashes, resulting in 9,152 total fatalities.

"In 2004, teen drivers constituted only 6.3 percent of licensed drivers, but were involved in 13.6 percent of all highway fatal crashes and 18 percent of all police-reported crashes.

"The risk of a crash involving a teenage driver increases with each additional teen passenger in the vehicle."

States should:

- "Enact laws to provide for a three-stage graduated licensing system for young novice drivers." The three stages are learner's permit, provisional license and full license."
- "Restrict young, novice drivers with provisional (intermediate) licenses , unless accompanied by a supervising adult driver who is at least 21 years old, from carrying more than one passenger under the age of 20."
- Prohibit holders of learner's permits and provisional licenses from using cell phones while driving. "Learning how to drive and becoming comfortable in traffic requires all the concentration a novice driver can muster," the board declares.

Mathern's bill includes all three elements of the National Transportation Safety Board's recommendations. The North Dakota Legislature should enact his bill, secure in the knowledge that the action will save teens' lives.

Medicare Reimbursement for Trauma Code Activations

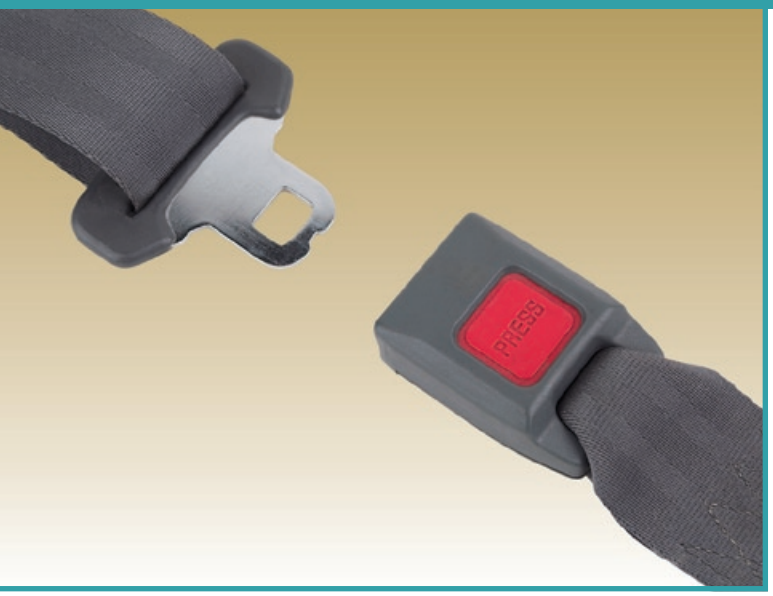
There is good news for trauma designated hospitals! For CY 2007, CMS will pay for critical care at two levels, depending on whether trauma activation occurs. Providers will receive one payment rate for standard critical care and will receive additional payment when critical care is associated with trauma activation.

When critical care is provided without trauma activation, the hospital will bill CPT code 99291 (and 99292, if appropriate) as usual, and receive payment for APC 0617 (critical care), which has a median cost of $402.67.

Effective January 1, 2007, the hospital will bill critical care provided with trauma activation with a new G-code, G0390 (Trauma response team activation associated with hospital critical care service) and receive payment for APC 0618, which will have a median cost of $491.66. To determine whether trauma activation occurs, CMS will follow the National Uniform Billing Committee or NUBC guidelines related to the reporting of the trauma revenue codes in the 68x series, i.e., the provider must be licensed as a trauma center, must have been pre-notified, and must give the appropriate trauma team response to the patient.

There is a more detailed discussion of this in the OPPS final rule, which may be found at the following website: http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1188344&intNumPerPage=10 (the first link under "Downloads").

What's Holding You Back?



North Dakota Facts

Upgrading North Dakota's Safety Belt Law to Standard Enforcement

Driving Toward Zero Deaths

What does 'standard enforcement' mean?

Upgrading North Dakota's safety belt law from secondary to standard enforcement allows law enforcement officials to issue safety belt citations without having to first witness additional violations, such as speeding or running a stop sign. No violation in addition to a safety belt violation would need to occur for an officer to pull over a vehicle.

What will standard enforcement do?

Based on national statistics, states see a dramatic increase in safety belt use after enacting standard law. In general, states with the standard enforcement classification have the highest safety belt use. On average, states experience an 11 percentage point increase in safety belt use by upgrading the law to standard. The table below illustrates the progress of several states that upgrade safety belt laws.

	Standard Upgrade Date	Use Rate BEFORE Standard Law	Use Rate AFTER Standard Law	2005 Rate
Michigan	2000	70%	83%	93%
Washington	2002	81%	93%	95%
Illinois	2003	74%	83%	86%

Public Health Concern

Safety belt use is a public health concern – Standard Enforcement will save lives and prevent injuries.

- Based on other states' experiences, North Dakota's safety belt use rate would increase from 76.3 percent to 87.3 percent as a result of standard enforcement – preventing more than eight deaths and nearly 60 serious injuries annually – directly impacting health care costs.
- Traffic crashes are the leading cause of injury death for North Dakotans (North Dakota Department of Health). Each year, the majority of people killed in crashes are unrestrained. (Source: North Dakota Department of Transportation, Office of Traffic Safety)
- The Fall 2000 National Occupant Protection Use Survey showed that overall shoulder belt use in states with

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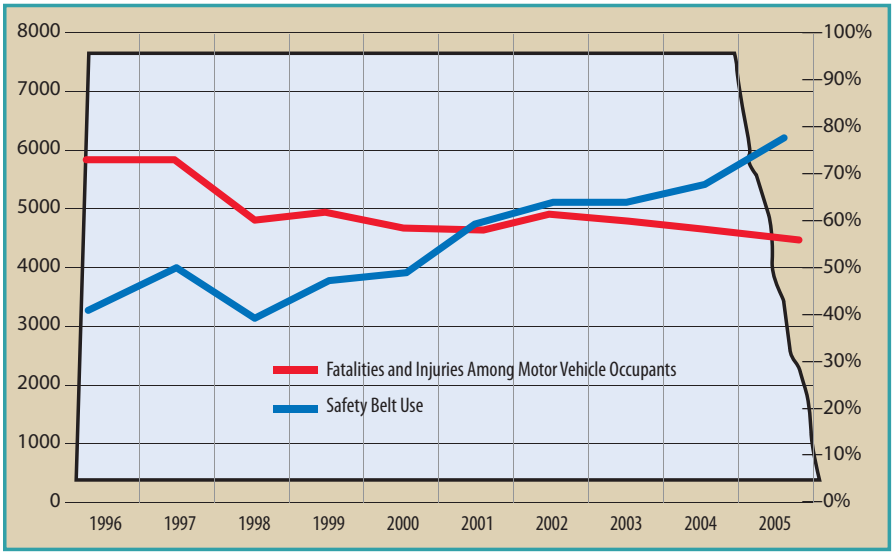
standard enforcement safety belt laws was 77 percent compared with 64 percent in states without standard enforcement laws. (Source: National Highway Traffic Safety Administration)

North Dakota Traffic Fatalities and Injuries Compared with Safety Belt Use, 1996-2005



Safety Belt Facts:

- In 2005, there were 123 traffic fatalities in North Dakota. Approximately 70% of the motorists were unrestrained. (Source: National Highway Traffic Safety Administration, ND Highway Patrol)
- The safety belt usage rate, released by the National Highway Traffic Safety Administration, September, 2005, was 82 percent.
- When used, lap/shoulder safety belts reduce the risk of fatal injury to front seat passenger car occupants by 45 percent and the risk of moderate-to-critical injury by 50 percent. (Source: National Highway Traffic Safety Administration)
- For light truck occupants, safety belts reduce the risk of fatal injury by 60 percent and moderate-to-critical injury by 65 percent. (Source: National Highway Traffic Safety Administration)
- From 1975 through 2005, an estimated 211,128 lives were saved by safety belts. (Source: National Highway Traffic Safety Administration)

Q: What is the national experience of states upgrading to standard enforcement belt laws?

A: As of May, 2006, 25 states, Puerto Rico, the Virgin Islands, and the District of Columbia have standard safety belt laws in effect. Listed below is the year that legislation was passed in each state or territory:

Alabama – 1999
Alaska – 2005
Delaware – 2003
California – 1993
Connecticut – 1986
District of Columbia – 1997
Georgia – 1996
Hawaii – 1985
Illinois – 2003
Indiana – 1998
Iowa – 1986
Louisiana – 1995
Maryland – 1997
Michigan – 2000
Mississippi – 2006
Missouri – 2005
New Jersey – 1999
New Mexico – 1986
New York – 1984
North Carolina – 1985
Oklahoma – 1990
South Carolina – 2006
Tennessee – 2004
Texas – 1985
Washington – 2002

The link below is for online free trauma education. You will have to create an account and they do require your nursing license number. This site is put together in Florida by the Trauma Program Managers there. There have been rave reviews about it on the Society of Trauma Nurses list serve.

www.traumaed.com